MEDICAID PROVIDER INFORMATION

Qualifications for Enrollment

General Requirements

Licensure – Providers must be licensed, accredited and/or certified according to the specific laws and regulations that apply to their service type. Enrollment requirements vary, but most providers must complete an application and a N.C. participation agreement. All providers are responsible for maintaining the required licensure and accreditation specific to their provider type to remain qualified as a N.C. Medicaid provider. For detailed information regarding specific requirements for each provider type refer to DMA's website at http://www.dhhs.state.nc.us/dma/provenroll.htm or call DMA Provider Services at 1-919-855-4050.

Service Location – Services must be provided at a site location in North Carolina or within 40 miles of the North Carolina border. Out-of-state providers beyond 40 miles of the North Carolina border may enroll in the N.C. Medicaid program to provide emergency or prior approved services only. Providers must bill using their site specific provider number.

Provider Agreements – Providers sign participation agreements with DMA. These agreements contain general requirements for all providers as well as specific requirements for each service type.

All providers are responsible for ensuring that information on file with the Medicaid program for their practice or facility remains up-to-date. Refer to **Reporting Provider Changes** on page 3-5 for information on reporting changes in provider status to the Medicaid program.

Enrollment Procedure

Providers that wish to enroll must complete and application and agreement for the specific provider type. Applications and agreements are locations on DMA's website at http://www.dhhs.state.nc.us/dma/provenroll.htm.

Once an application packet is received and processed by DMA, providers are assigned a provider number and are notified by mail once the enrollment process has been completed. Processing times varying according to provider type. The Provider Enrollment staff research the OIG sanctions, Senate Bill 926, appropriate medical board data bases and other sources for verification that a provider is in good standing prior to enrollment. Providers are referred to DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm for Medicaid service information.

Tax Information

To ensure that 1099 MISC forms are issued to providers correctly, proper tax information must be on file for all providers. This will also ensure that the correct tax information is provided to the IRS.

Independent practitioners such as physician, dentists, nurse practitioners, etc., are assigned individual attending Medicaid providers numbers. Most often these numbers are linked to the provider's social security number. When an independent practitioner provides services in a group setting, the group provider number is indicated on the claim form along with the individual provider number. The claim will pay to the group number and report to the group tax id. Individual providers should not link their individual provider numbers to group tax identification numbers.

The last page of the Remittance and Status Report (RA) indicates the provider tax name and number (FEIN) that Medicaid has on file. Review the RA throughout the year to ensure that the correct provider number information is on file with EDS. The tax information needed for a group practice is as follows:

1. group tax name and group tax number
2. attending Medicaid provider numbers in group

Providers may also verify the tax information by calling EDS Provider Services at 1-800-688-6696 or 919-851-8888.

The procedure for submitting corrected tax information to the Medicaid program is as follows:

- All providers must submit completed and signed W-9 forms along with a completed and signed **Provider Change Form** to Medicaid at the address listed below:

  Division of Medical Assistance
  Provider Services
  2501 Mail Services Center
  Raleigh, NC 27699-2501

Providers must also report changes of ownership and group practice changes. For more information, refer to **Reporting Provider Changes** on page 3-5.

Conditions of Participation

Civil Rights Act

Providers must comply with Title VI of the Civil Rights Act of 1964, which states "No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation under any program or activity receiving federal financial assistance."

Rehabilitation and Disabilities Acts

Providers must comply with the following requirements in addition to the laws specifically pertaining to Medicaid:

- **Section 504 of the Rehabilitation Act of 1973**, as amended, which states "No otherwise qualified handicapped individual in the United States shall solely by reason of his handicap, be excluded from the participation in, be denied the benefit of, or be subject to discrimination under any program or activity receiving Federal financial assistance."
- **The Age Discrimination Act of 1975,** as amended, which states, "No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance."
- **The Americans with Disabilities Act of 1990**, which prohibits exclusion from participation in or denial of services because the agency's facilities are not accessible to individuals with a disability.

Disclosure of Medicaid Information

The provider must comply with the requirements of the Social Security Act and federal regulations concerning:

1. the disclosure of ownership and control information by providers (other than an individual practitioner)
2. the disclosure of any felony convictions by a provider or any owners
3. the disclosure of any disciplinary action taken against business or professional licenses by a provider

4. the disclosure of any denial of enrollment, suspension or exclusion from Medicare or Medicaid in any state or employment by a corporation, business or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state
5. the disclosure regarding any suspended payments from Medicare or Medicaid in any state or employment by a corporation, business or professional association that ever had suspended payments from Medicare or Medicaid in any state

Medical Record Documentation

As a condition of participation, Medicaid providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid program. Records must be retained for a period of not less than five years from the date of service unless a longer retention period is required by applicable federal or state law, regulations or agreements. Copies of records must be furnished upon request. HIPAA does not prohibit the release of records to Medicaid. Record documentation is used by DMA to determine medical necessity and verify services were billed correctly.

The following principles of documentation are adopted from Medicare policy:

1. The medical record must be complete and legible.
2. The documentation of each patient encounter must include the date and reason for the encounter as well as relevant history, physical examination findings, and prior diagnostic test results; assessment; clinical impression or diagnosis; services delivered; plan for care including drugs and dosage prescribed or administered; and legible signature of the observer.
3. Past and present diagnoses and health risk factors must be identified and accessible to the treating and/or consulting physician.
4. The rationale for diagnostic tests and other ancillary services must be documented or apparent in the medical record.
5. The patient's progress, including response to and change in treatment, must be documented. Reasons for diagnostic revision must be documented.
6. The documentation must support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision making.
7. The CPT, HCPCS, and ICD-9-CM codes reported on the health insurance claim form or billing statement must be supported by the documentation in the medical record.

Payment in Full

The provider must agree to accept the amount paid for Medicaid covered services as payment in full in accordance with the rules and regulations for reimbursement, promulgated by the Secretary of DHHS and by the State of North Carolina, and established under the Medicaid program, with the exception of authorized copayments by recipients.

Fee Schedule Requests

There is no charge for fee schedules or reimbursement plans requested from DMA. The information that is provided is to be used only for internal analysis. Providers must bill their usual and customary rate. Requests for fee schedules and reimbursement plans must be made on the **Fee Schedule Request form** (see page 3-14) and mailed to the address listed on the form. The Fee Schedule Request form may also be faxed to DMA's Finance Management section at 919-715-2209. Requests by phone are not accepted.

Many of the fee schedules are also available on DMA's website at
http://www.dhhs.state.nc.us/dma/fee/fee.htm

Provider Responsibilities

Verifying Recipient Eligibility

Providers are responsible for verifying Medicaid eligibility when a recipient presents for services. Refer to **Verifying Eligibility** on page 2-10 for additional information

Billing the Recipient

When a noncovered service is requested by a recipient, the provider must inform the recipient either orally or in writing that the requested service is not covered under the Medicaid program and will, therefore, be the financial responsibility of the recipient. This must be done prior to rendering the service.

A provider may refuse to accept a Medicaid recipient and bill the recipient as private pay **only** if the provider informs the recipient prior to rendering the service, either orally or in writing, that the service will not be billed to Medicaid and that the recipient will be responsible for payment.

A provider may also bill a Medicaid recipient for:

- Payments for services that are made to the recipient and not the provider by either commercial insurance or Medicare.
- The recipient has MEDICARE-AID (MQB-Q) coverage and the service is non-covered by Medicare. (MQB-Q recipients receive a buff MEDICARE-AID card.)
- The provider may bill a patient accepted as a Medicaid patient for allowable Medicaid deductibles or copayments.
- Prescriptions in excess of the six-per-month limit.
- The recipient exceeds the 24-visit limit for provider visits for the state fiscal year (July 1 through June 30).
- The recipient's failure to provide proof of eligibility by presenting a current MID card.
- The patient is no longer eligible for Medicaid as defined in 10 A NCAC 21B.
- The portion of psychiatric services for a Medicare eligible recipient that have had the Medicare reimbursement reduced by 37.5 percent psychiatric reduction.

Third Party Liability

State and federal regulations for Third Party Liability (TPL) require responsible third party insurance carriers to pay for medical services prior to a provider submitting a claim to Medicaid. Providers are required to seek payment from third party insurance carriers when they know of their existence. A third party insurance carrier is an individual or company who is responsible for the payment of medical services. These third parties are Medicare, private health insurance, auto or other liability carriers. DMA's Third Party Recovery (TPR) unit is responsible for implementing and enforcing TPL laws. The TPR unit implements and enforces these laws through both cost avoidance and recovery methods. Refer to **Third Party Liability Section** on page 7-5 for additional information.

Overpayments

The Program Integrity (PI) section of DMA conducts regular postpayment reviews in an ongoing effort to:

- Determine a statistical payment accuracy rate for claims submitted by providers and paid by Medicaid.
- Assure that Medicaid payments are made only for services that are covered under Medicaid policy.
- Verify that coding on Medicaid claims correctly reflects the services that were provided.
- Assure that third party carriers are billed before Medicaid was billed and that providers reported any such payments from third parties on claims filed for Medicaid payment.

When overpayments are identified, providers are given written information about the errors and are required to refund the overpayment amount.

Reporting Provider Changes

What Changes Must be Reported

All providers are required to report all changes in status to Medicaid. This includes changes of ownership (within 30 days), name, address, tax identification number, licensure status, and the addition or deletion of group members.

Managed Care providers (Carolina ACCESS [CCNC], ACCESS II/III, HMOs, and PCHP) must also report changes in daytime or after-hours phone numbers, counties served, enrollment restrictions, etc. CCNC providers must report Medicaid provider number changes immediately to ensure that CCNC management fees are paid correctly

Failure to report changes in provider status may result in suspension of the Medicaid provider number and a delay in your receipt of claims reimbursement. In addition, providers may be liable for taxes on income not received by their business.

How to Report a Change

Refer to the back of the **Medicaid Provider Change Form** on page 3-15 to determine the appropriate process for reporting changes in provider status according to your specific provider type. Carolina ACCESS (CCNC) providers and ACCESS II/III providers must also report changes using the **Carolina ACCESS Provider Information Change Form** on page 3-17. Both forms are also available on DMA's website at http://www.dhhs.state.nc.us/dma/forms.html.

Voluntary Termination

All providers must notify DMA in writing at the address listed below of their decision to terminate their participation in the N.C. Medicaid program. Notification must be on the provider's letterhead and signed by the provider, office manager or administrator.

Division of Medical Assistance
Provider Services
801 Ruggles Drive
2501 Mail Service Center
Raleigh, NC 27699-2501

Managed Care providers must also notify additional parties to request termination.

- Carolina Access (CCNC) and ACCESS II/III providers must send in a completed Carolina ACCESS Provider Information Change Form requesting termination from the program. This must be addressed to DMA Provider Services at the above address.

HMO providers and PCHP must notify DMA's Managed Care section of their decision to terminate. Refer to page 4-6 for additional information.

Termination of Inactive Providers

If an enrolled Medicaid provider does not bill Medicaid within 12 months the Division will send notice of termination of the Medicaid provider number. A provider will have two weeks to respond with a justification if they wish to remain enrolled as a Medicaid provider. These notices are sent to the current mailing address listed in the provider's file. Once terminated, providers must complete a new application and agreement to become re-enrolled and may have a lapse in Medicaid eligibility as a Medicaid provider.

Payment Suspension

If RAs and checks cannot be delivered due to an incorrect billing address in the provider's file, all claims for the provider number are suspended and the subsequent RAs and/or checks are no longer printed. Automatic deposits are also discontinued. Once a suspension has been placed on the provider number, the provider has 90 days to submit an address change. After 90 days, if the address has not been corrected, claims in suspension will deny and the provider number is terminated.

Licensure Revocation or Suspension

Any provider or facility whose license(s) is revoked or suspended is not eligible for participation in the N.C. Medicaid program. All providers should notify DMA immediately if their license is revoked or suspended.

Reactivation in the Medicaid program may occur when the license is reinstated by the licensing authority. Reactivation must be requested in writing by the provider or the facility. A copy of the reactivated license must accompany the request for reactivation. Reactivation is effective no earlier than the date on the reinstated license.

Sanctions

Providers who receive sanction(s) from CMS may become ineligible for Medicaid participation and may be responsible for refunding any Medicaid payments made to them while under a CMS sanction(s). CMS will notify DMA of providers who are sanctioned. Any provider who is sanctioned should notify DMA immediately.

Program Integrity Reviews

Determining Areas for Review

PI reviews are initiated for a variety of reasons. The following are examples of reviews conducted by PI:

- PI investigates specific complaints and referrals. These may come from recipients, family members, providers, state or county agencies or other DMA sections.
- PI uses a Fraud and Abuse Detection System (FADS), which consists of two software products called HealthSPOTLIGHT™ and OmniAlert™.

HealthSPOTLIGHT™ uses fraud and abuse pattern recognition software, algorithms, statistical analysis, fraud filters, queries, and neural net technology to identify fraud and abuse claims.

1. OmniAlert™ is PI's client server Surveillance and Utilization Review System (SURS). OmniAlert™ is an on-demand, real-time product that makes comparisons of provider billings to determine aberrant billing patterns among peer groups.
2. Additional features such as claims imaging, the claims data warehouse, and ad hoc query tools along with FADS software also make detection and investigation faster.

- Special ad-hoc DRIVE computer reports that target specific issues, procedure codes or duplications of services, etc.
- The Office of the State Auditor pulls a stratified sample of claims annually. PI staff review these claims to determine the payment accuracy rate for claims submitted by providers and paid by the Medicaid MMIS+ system.
- PI staff also conduct a second sampling of provider billings using methodology prescribed by CMS. This is to assist CMS in complying with HR 4878, the Improper Payments Act of 2002.
- DMA is also participating as a pilot state in a national project called Medi-Medi. In this project, Medicare and Medicaid claims are stored in a combined data warehouse. The data is then mined to identify possible fraud and abuse.
- EDS refers questionable services identified during claims processing to PI.

Provider Responsibilities with a Program Integrity Review

If you are notified that PI has initiated a review, you should adhere to the following steps:

- PI will request medical and/or financial records either by mail or in person. The records must substantiate all services and billings to Medicaid. Failure to submit the requested records will result in recoupment of all payments for the services. You must maintain records for five years in accordance with the recordkeeping provisions of your provider participation agreement.
- If you receive a recoupment letter from PI, review the information in the letter and chart. You have two options:
    1. If you agree that an overpayment has occurred, use the form sent with the letter to indicate your preferred method for reimbursing DMA. The options include sending a check or having the repayment withheld from future Medicaid payments. Please send your check to DMA Accounts Receivable at the address on the letter. **Do not** send the check to EDS as this could result in a duplication of your refund. Also, Do NOT request that EDS adjust for the amount or items identified, as this could result in duplicate recoupment.
    2. If you disagree with the overpayment decision by PI and want a reconsideration review, return the enclosed hearing request form to the DMA Hearing Unit (at the address on the letter) and indicate whether you request a personal hearing or a paper review. **Please pay close attention to the time frames and procedures for requesting a reconsideration review.**

Request for Reconsideration

Informal Hearings – If a provider disagrees with a DMA decision they may have the right to an informal hearing. If applicable, the provider will be notified of their right an informal hearing and these are conducted in Raleigh. The Hearing Unit will notify the provider of the date, time and location.

Paper Reviews – You may instead send any additional relevant documentation to the Hearing Unit for reconsideration. Your written material will then be evaluated and a final decision rendered.

Miscellaneous

- For assistance or education, please call EDS at 919-851-8888 or 1-800-688-6696.
- It is the provider's responsibility to maintain the medical coverage policies and Medicaid bulletins and ensure that all staff who plan care, supervise services, and file claims for Medicaid reimbursement have access to and follow these Medicaid guidelines.

Self-Referral Federal Regulation

For Medicaid payments, OBRA 1993 prohibits self-referral by a physician to designated health services in which the physician has certain ownership or compensation arrangements. Designated health services include the following:

- clinical laboratory services
- outpatient drugs
- durable medical equipment
- parenteral and enteral nutrition equipment and supplies
- comprehensive outpatient rehabilitation facility services
- contact lenses
- physical and occupational therapy services
- home infusion therapy services
- prosthetic and orthotic devices
- eyeglasses
- radiation therapy services
- inpatient and outpatient hospital services
- radiology services (including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services)
- hearing aids
- home dialysis
- home health services
- ambulance services

If postpayment review determines that inappropriate payments were made due to the provider's failure to follow Medicaid policies, recoupments will be made. Exceptions are listed in OBRA 1993 and in section 1877 of the Social Security Act.

Advance Directives

Section 4751 of the OBRA 1990, otherwise known as the Patient Self-Determination Act, requires certain Medicaid providers to provide written information to all patients 18 years of age and older about their rights under state law to make decisions concerning their medical care, to accept or refuse medical or surgical treatment, and to execute an advance directive (e.g., living will or health care power of attorney).

Effective January 1, 1998, a new law entitled "An Act to Establish Advance Instruction for Mental Health Treatment" (NCGS §122C-71–§122C-77) became effective. The law provides a method for an individual to exercise the right to consent to or refuse mental health treatment if the individual later becomes "incapable" (i.e., lacks the capacity or ability to make and communicate mental health treatment decisions). The advance instruction becomes effective when delivered to the individual's physician or mental health treatment provider, who then makes it part of the individual medical record.
DMA, in conjunction with an advisory panel, has developed the required summary of state law concerning patients' rights that must be distributed by providers. This brochure is entitled ***Medical Care Decisions and Advance Directives: What You Should Know***. A print-ready copy is available on page 3-19.

The two-page brochure can be photocopied on the front and back of one sheet of paper and folded in half to form a four-page brochure. Indicate in the box on the last page a contact for the patient to obtain more information. The brochure should be copied as is. If providers choose to alter the document graphically, they may not change or delete text, or the order of paragraphs. A provider-published pamphlet must include the N.C. DHHS logo and production statement on page four of the folded brochure.

Provider Information – Commonly Asked Questions

1. What are the requirements for enrollment in the N.C. Medicaid program?

Providers must be licensed and accredited according to the specific laws and regulations that apply to their service type. Providers must complete an application and agreement and provide verification of licensure, if applicable. Refer to the DMA website at http://www.dhhs.state.nc.us/dma/provenroll.htm for specific credentialing requirements.

2. Where can I get an enrollment application?

Applications for enrollment as a **Medicaid provider** are available from DMA Provider Services on our website at: http://www.dhhs.state.nc.us/dma/provenroll.htm. Written requests may be sent to the address below:

Division of Medical Assistance
Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

3. How do I enroll as a Medicaid Managed Care provider?

- Applications for participation as a Carolina ACCESS (**CCNC**) **provider** are available from DMA's website at http://www.dhhs.state.nc.us/dma/provenroll.htm.
- To enroll as an ACCESS II/III provider, contact the Office of Research, Demonstrations, and Rural Health Development at 919-715-7625.
- To enroll as an HMO provider in Mecklenburg County, contact the HMO directly.
- To enroll as a Piedmont Cardinal Health Plan (PCHP) provider, contact Piedmont Provider Relations at 1-800-958-5596.

For additional information, contact DMA Provider Services at 919-855-4050 or the regional Managed Care Consultant for your county.

4. How are group provider numbers assigned?

Group provider numbers are assigned to each physical site that delivers services to Medicaid recipients. If a group practice has 10 sites, each site must have a separate provider number. Individual providers are not issued separate numbers if they practice at more than one site; their individual numbers can be linked to several groups or from one group to another. Groups must notify DMA when an individual practitioner is added to or deleted from their group practice.

5. When can I begin billing for services I have rendered to Medicaid recipients?

Prospective Medicaid providers must apply for and be enrolled in the Medicaid program, assigned a provider number, and agree to certain conditions of participation before payment can be made for services rendered to Medicaid recipients. The effective date on the participation agreement is the earliest date a provider may begin billing for services.

Provider Information – Commonly Asked Questions (continued)

6. How often do I have to re-enroll as a Medicaid provider?

Enrollment periods vary according to service types. Some enrollment periods are end-dated and require the provider to initiate the re-enrollment process at a specified time by contacting DMA Provider Services at 919-855-4050.

All providers are responsible for maintaining the required licensure and accreditation specific to their provider type to remain qualified as a N.C. Medicaid provider.

All providers are responsible for ensuring that information on file with N.C. Medicaid for their service or facility remains up to date.

7. Is it necessary for a physician who already has a Medicaid provider number to notify DMA if he/she transfers to a new practice?

Yes. While re-enrollment is not necessary the physician must notify DMA they are no longer linked to the old group practice and ask that they be linked with their new group practice. The new group must complete the Provider Change form located on DMA's website. A physician will usually keep the same individual provider number. If billing under a group provider number, the group may begin billing for the new physician as long as the physician's individual provider number is active.

8. Are we required to apply for a new provider number if our group merges with another group and our group tax ID number changes?

Yes. A provider must apply for a new group provider number but the provider's individual provider numbers will remain the same. If you are merging groups but will still have separate locations, each office site must apply for a new group provider number.

9. Are individual providers required to apply for a new provider number if there is a change to the tax ID number?

No. But, providers must notify the Medicaid program of the tax ID number changes.

10. If I have an individual provider number and I leave a group practice do I need to change my tax id number to the new groups tax id number?

No. An individual provider number belongs to the individual provider. The provider's Social Security Number or the FEIN tax number should not be changed when an individual provider leaves a group practice. When the provider joins a group and renders services, the group provider number must go in Block 33 of the CMS 1500 under "Grp". The provider who rendered the service must put their individual provider number in Block 33 under "PIN". The payment will be made to the group and reported under the group's tax id number.

11. How do I contact the Medicaid program to report changes to my provider status?

The Provider Change form is located on our website at http://www.dhhs.state.nc.us/dma/forms.html#prov Refer to **How to Report a Change** on page 3-5 for information on reporting changes in your provider status to the Medicaid program.

Provider Information – Commonly Asked Questions (continued)

12. I am currently a Carolina ACCESS provider and my Medicaid provider number has changed. How do I report this change?

Changes must be reported to DMA Provider Services using the **Carolina ACCESS Provider Information Change form on our website at http://www.dhhs.state.nc.us/dma/forms.html#ca** (see page 3-17).

If the Medicaid provider number that is changing is also your Carolina ACCESS (CCNC) provider number, DMA Provider Services must be alerted as soon as possible to ensure that the Carolina ACCESS (CCNC) management fee is paid properly and to prevent claim denials. Until you receive notification that your CCNC number has been changed, claims filed using your new Medicaid provider number must also include your old Medicaid provider number (current CCNC number) in block 19 of the CMS-1500 claim form. It is imperative that you use your active CCNC number when you refer patients.

13. If our practice is participating as a provider in the Carolina ACCESS or ACCESS II/III program, who do I contact when there is a change in our practice's provider number?

CCNC providers must report all changes to DMA Provider Services using the **Carolina ACCESS Provider Information Change form on our website at http://www.dhhs.state.nc.us/dma/forms.html#ca** (see page 3-17). When reporting a change in ownership, CCNC providers must submit a new Carolina ACCESS enrollment application package.

All providers must report changes to DMA using the **Provider Change Form** (see page 3-15).

14. If our practice is participating in an HMO with the Medicaid program, who do I contact when there is a change in our practice's provider information?

HMO providers must report all changes to their HMO(s).

15. My organization participates with the Medicaid program as an administrative entity for ACCESS II/III. Who do I contact when there is a change in our provider status?

Report changes to the Office of Research, Demonstrations, and Rural Health Development at 919-715-7625.

16. My organization contracts with Medicaid as an HMO Risk Contracting Managed Care plan. Who do I contact when there is a change in our provider status?

Report changes to DMA Provider Services using the **Medicaid Provider Change Form** (see page 3-15).

17. I am currently enrolled as a Community Alternatives Program (CAP) provider. How do I amend my enrollment to include additional services?

CAP providers who are currently enrolled in the Medicaid program must send a completed enrollment application and verification of appropriate licensure and certification to DMA Provider Services at the address listed below. However, it is not necessary to complete a new agreement. Applications may be obtained from DMA Provider Services at the address listed below or on DMA's website at http://www.dhhs.state.nc.us/dma/provenroll.htm.

Division of Medical Assistance
Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501

18. My specialty is listed incorrectly. How do I correct it?

Requests to change a provider's specialty must be submitted in writing to DMA Provider Services at the address listed below. Requests must be written on letterhead and include the provider number and correct specialty.

Division of Medical Assistance
Provider Services
801 Ruggles Drive
2501 Mail Service Center
Raleigh, NC 27699-2501

19. How do I terminate my enrollment as a Medicaid provider?

Providers must notify DMA Provider Services in writing at the address listed below of their decision to terminate their participation in the Medicaid program. Notification must be on the provider's letterhead and signed by the provider, office manager or administrator.

Division of Medical Assistance
Provider Services
801 Ruggles Drive
2501 Mail Service Center
Raleigh, NC 27699-2501

20. How do I terminate my enrollment as a Managed Care provider?

Managed Care providers (Carolina ACCESS [CCNC], ACCESS II/III) must notify DMA Provider Services at least 30 days in advance in writing of their decision to terminate their participation in the Managed Care program. Notification must be sent by registered mail with return receipt request to the address listed below.
Division of Medical Assistance
Provider Services
801 Ruggles Drive
2501 Mail Service Center
Raleigh, NC 27699-2501

21. My practice has opened up another site location. Can I use their current group number?

No. You must enroll with one group number per site location. This applies to both Medicaid and Carolina ACCESS (CCNC) programs.

SAMPLE OF FEE SCHEDULE REQUEST FORM

There is no charge for fee schedules requested from the Division of Medical Assistance (DMA). **Providers are expected to bill their usual and customary rate.** Please note that fee schedules change regularly and you will be provided the most current version upon the receipt of your request.
All requests for fee schedules **must be made** on the Fee Schedule Request form and mailed to:

Division of Medical Assistance
Finance Management/Rate Setting - Fee Schedules
2501 Mail Service Center
Raleigh, N. C. 27699-2501

Or **fax** your request to DMA's Finance Management/Rate Setting section at **919-715-2209**.
Please note that many fee schedules can be directly accessed and obtained at our website www.dhhs.state.nc.us/dma. If you can not get your schedule then submit this form.

NOTE: PHONE REQUESTS ARE NOT ACCEPTED

- ☐ Adult Care Homes Personal Care Services (ACH-PCS)
- ☐ Ambulance
- ☐ Community Alternatives Program (CAP-MR/DD, CAP-AIDS, CAP-DA, CAP-C)
- ☐ Dental
- ☐ Durable Medical Equipment
- ☐ Health Department
- ☐ Home Health
- ☐ Home Infusion Therapy
- ☐ Hospice
- ☐ Licensed Clinical Social Worker
- ☐ Licensed Psychologist
- ☐ Nurse Midwife
- ☐ Occupational Therapist
- ☐ Orthotics and Prosthetics
- ☐ Physical Therapist
- ☐ Physician Fees (includes x-ray and laboratory, nurse midwife, optical)
- ☐ Respiratory Therapy
- ☐ Speech Therapy

Name(Provider/Facility): _____ Provider Type: _____

Address: _____ Provider #: _____

E-Mail Address_____

Contact Person: _____ Phone: _____

Date of Request: _____

Format of fee schedule requested (circle one of each) **Emailed** or **Disk copy** / **Excel** or **Adobe version**

MEDICAID PROVIDER CHANGE FORM

Date: _____

Medicaid Provider Number (Required): _____

Medicaid Provider Name: _____

Type of Provider: (select one)

☐ Group Provider	☐ Individual Provider	☐ Other_____

Type of Change: (select all that apply)

☐ Change of Business Name (attach completed W-9)	☐ Change of Ownership (attach completed W-9)	☐ Change of Tax ID Number (attach completed W-9)	☐ Address Change **OR** ☐ Termination

Terminate Medicaid Participation Effective date):_____

Reason: _____

Change Medicaid Provider Physical Address to: _____
(If applicable, attach a copy of facility license) _____

_____

Contact Name: _____
Telephone Number: _____
Email Address: _____

Change Medicaid Provider Payment Address to: _____

_____

_____

Add or Delete Participating Individual Provider(s) to/from Medicaid Group:

	Individual Provider Name	Individual Medicaid Provider Number (Required)	Social Security Number	License Number
❑add ❑delete				
❑add ❑delete				
❑add ❑delete				
❑add ❑delete				

Note: If you are a Carolina ACCESS provider, please complete the Carolina ACCESS Provider Change Form on our website at http://www.dhhs.state.nc.us/dma/Forms/capicf.pdf

Authorized Signature: _____ **Date:** _____

_____

Typed or Printed Name and Title of Authorized Signature Above

Mail this form to: **DMA Provider Services, 2501 Mail Service Center Raleigh, NC 27699-2501** or fax to **919-715-8548.**

(Revised 4/20/05)

All Carolina ACCESS and ACCESS II Providers must, also, complete the Carolina ACCESS Provider Change Form or obtain a copy of the form by calling Provider Services @ 919-855-4050.

These Medicaid providers must report all changes to the Division of Medical Assistance using this form.
ACCESS II Providers & Administrative Entities – Also, report changes to the N.C. Office of Research, Demonstrations, and Rural Health Development (919-715-7625).
Ambulance Services
Certified Registered Nurse Anesthetists
Chiropractors
Community Alternative Program Services - DMA Provider Services contacts you to obtain additional information as needed to complete your change request.
Dentists
Developmental Evaluation Centers
DSS Case Management
Durable Medical Equipment Services - **Include a copy of your new license**.
Federal Qualified Health Centers
Head Start Programs
Health Departments
Hearing Aid Dealers
HIV Case Management
Home Infusion Therapy Services - **Include a copy of your new license**.
HMO Risk Contracting Managed Care Plans
Independent Diagnostic Treatment Facilities
Freestanding Birthing Centers - Include a copy of your new accreditation from the Commission of Free-Standing Birthing Centers.
Independent Freestanding Laboratories - Include a copy of your new CLIA certificate.
Independent Practitioners (Audiologists, Occupational Therapists, Physical Therapists, Respiratory Therapists, Speech Therapists)
Licensed Clinical Social Workers
Licensed Psychologists
Mental Health Centers
Nurse Midwives
Nurse Practitioners
Optical Services
Optometrists
Osteopaths
Out-of-State Hospitals
Personal Care Services - **Include a copy of your new license**.
Physicians
Planned Parenthood Programs
Pharmacies - Include a copy of your new license.
Private Duty Nurses - Include a copy of your new license.
Psychiatric Clinical Nurse Specialist
Psychiatric Nurse Practitioners
Public School Health Programs
Residential Evaluation Centers
School Based Health Centers

The providers listed here must also report changes to the Division of Facility Services by calling (919) 733-1610.
Adult Care Homes
Ambulatory Surgical Centers
Critical Access Hospitals
Dialysis Centers
Home Health Agencies
Hospice
Intermediate Care/Mental Retardation Facilities
In-State Hospitals
Nursing Facilities
Portable X-Ray Suppliers
Psychiatric Residential Treatment Facilities
Residential Child Care Facility (Level II – IV)
Rural Health Clinics

Sample of Carolina ACCESS Provider Information Change Form

CAROLINA ACCESS PROVIDER INFORMATION CHANGE FORM

For DMA Office Use Only

EIS_____EDS_____ACCESS_____COUNTY_____

Date:_____

CA Practice Name:_____

CA Practice Provider Number:_____ **County:**_____

This CA practice requests the following change(s) be made to their CA application and information contained in CA databases:

Change **CA practice name** to:_____
Please make change effective for CA (date):_____

Change **CA practice provider number** to:_____ Make change effective for CA (date):_____
Reason for number change:_____
_____

Terminate CA practice provider number effective (date):_____ Reason:_____
_____

Change **enrollment restriction information (i.e., ages 15 and up only)**:_____
_____
New enrollment restriction code(s):_____

Delete provider(s) from practice:_____
_____
_____

Add participating provider(s) to practice: (Note: Medical license number of all new provider(s) **and** individual Medicaid provider number of new physician(s) **must** be included.)

Provider Name	**Title**	**License Number**	**Individual Medicaid Provider Number (MDs Only)**

Change **CA practice site address** to:_____
_____

Change **CA practice mailing address** (if different from site address) to:_____
_____

Change **telephone** number to:_____ Change **after-hours** telephone number to:_____

Change **enrollment limit** from:_____ to:_____ (Note: maximum 2000 per participating provider in this practice.)

Change **contact person** to:_____ Title:_____

Add county(ies) served:_____ **Delete county(ies) served**:_____

Comments/Other:_____
_____
_____

Form Completed By:_____ **Title:**_____

Note: Please fax form to the **DMA Provider Services** at **(919) 715-8548** Changes will be entered in the database(s) and changes made to the CA application on file.

(Revised 10/01)

Sample of Carolina ACCESS Provider Information Change Form, continued

This form is intended for use when making a change in the information originally provided on the Carolina ACCESS (CA) PCP application. Providers are also responsible for ensuring that information on file with the **Medicaid** program for their practice or facility remains up-to-date. (Please refer to the January 2001 Special Bulletin I, *Provider Enrollment Guidelines* for information on notifying Medicaid of a change within your practice.) Medicaid bulletins and other valuable information are available on the Division of Medical Assistance's Internet web site at http://www.dhhs.state.nc.us/dma.

Multiple changes may be indicated on the same change form. The following information **must** be included for each change request:

- CA practice name
- CA practice provider number
- Name and title of the person at the practice requesting the change

Fax the completed form to DMA Provider Services at (919) 715-8548. **Note:** It is not necessary to fax the back of the form (instructions) with the change form.

When changing a CA practice provider number, the reason for the number change **must** be provided. When terminating a CA practice provider number, DMA will disenroll all enrollees from your practice effective on the first day of the next calendar month provided that the request is received prior to the 12th working day before the last day of the month. Requests received after that day will be made effective on the first day of the month following the next calendar month. Therefore, enrollees **may** remain enrolled **through the end of the month** following the notification of changes. Providers will be notified of the effective date of the termination.

When adding a participating provider to a practice, the provider's title (e.g., M.D., N.P., Midwife, P.A.) and the medical license number must be included for **all** new providers. The physician's individual Medicaid provider number **must** also be included on the form. For nurse practitioners, midwives, or physician assistants only the license number is required. If any of the required information is missing from the change form, the provider(s) cannot be listed as a CA provider with the practice.

A new CA application is required when any of the following occurs:

- The provider or representative who signed the CA Agreement is no longer with the practice.
- The practice has had a change in ownership.
- All the providers in the practice have changed since the original application and Agreement were signed.
- Multiple change forms have been submitted and the original application is no longer valid.

If a change form is submitted, but it is deemed appropriate to request a new CA application, the provider will be contacted by DMA

Note: When a new CA application and Agreement are sent to replace an existing application on file and the provider ID number is changing with the new application, a change form requesting the termination or cross referencing of the old number should be submitted together with the new application. This will prevent problems with management fee(s) and claim(s) payment(s). A new CA application can be obtained by calling DMA Provider Services at 919-857-4017.

Enrollment Restriction Codes

01 No restriction
02 Established patients only
06 MPW only (pink card)
07 Dialysis patients-including nephrology-only (in same or contiguous counties)
08 Chronic infectious disease patients only (in same or contiguous counties)
09 Oncology patients only (in same or contiguous counties)
10 Established patients and siblings
11 Newborns only
14 Two track clinics: facilities serving two distinct populations
15 Age restriction

Please call DMA Provider Services at 919-857-4017 if there are questions about the change form or the Carolina ACCESS application process.

Sample of Advance Directives Brochure

Medical Care Decisions and Advance Directives What You Should Know

What are My Rights?

Who decides about my medical care or treatment?

If you are 18 or older and have the capacity to make and communicate health care decisions, you have the right to make decisions about your medical/mental health treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your doctor or mental health provider. If you want to control decisions about your health/mental health care even if you become unable to make or to express them yourself, you will need an "advance directive."

What is an "advance directive"?

An advance directive is a set of directions you give about the health/mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

Do I have to have an advance directive and what happens if I don't?

Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions; and you have no living will, advance instruction for mental health treatment, or a person named to make medical/mental health decisions for you ("health care agent"), your doctor or health/mental health care provider will consult with someone close to you about your care.

doctor and each health care agent you named of the change. You can cancel your advance instruction for mental health treatment while you are able to make and make known your decisions, by telling your doctor or other provider that you want to cancel it.

Whom should I talk to about an advance directive?

You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your doctor or health care provider can answer medical questions. A lawyer can answer questions about the law. Some people also discuss the decision with clergy or other trusted advisors.

Where should I keep my advance directive?

Keep a copy in a safe place where your family members can get it. Give copies to your family, your doctor or other health/mental health care provider, your health care agent, and any close friends who might be asked about your care should you become unable to make decisions.

What if I have an advance directive from another state?

An advance directive from another state may not meet all of North Carolina's rules. To be sure about this, you may want to make an advance directive in North Carolina too. Or you could have your lawyer review the advance directive from the other state.

Where can I get more information?

Your health care provider can tell you how to get more information about advance directives by contacting:

This document has been developed by the North Carolina Division of Medical Assistance in cooperation with the Department of Human Resources Advisory Panel on Advance Directives 1991. Revised 1999.

Living Will

What is a living will?

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally and incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatments that would delay your dying, for example by using a breathing machine ("respirator" or "ventilator"), or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube ("artificial nutrition or hydration").

Health Care Power of Attorney

What is a health care power of attorney?

In North Carolina, you can name a person to make medical/mental health care decisions for you if you later become unable to decide yourself. This person is called your "health care agent." In the legal document you name who you want your agent to be. You can say what medical treatments/mental health treatments you would want and what you would not want. Your health care agent then knows what choices you would make.

How should I choose a health care agent?

You should choose an adult you trust and discuss your wishes with the person before you put them in writing.

Advance Instruction for Mental Health Treatment

What is an advance instruction for mental health treatment?

In North Carolina, an advance instruction for mental health treatment is a legal document that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide yourself. The designation of a person to make your mental health care decisions, should you be unable to make them yourself, must be established as part of a valid Health Care Power of Attorney.

Other Questions

How do I make an advance directive?

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the doctor or other provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be written and signed by you while you are still able to understand your condition and treatment choices and to make those choices known. Two qualified people must witness all three types of advance directives. The living will and the health care power of attorney also must be notarized.

Are there forms I can use to make an advance directive?

Yes. There is a living will form, a health care power of attorney form and an advance instruction for mental health treatment form that you can use. These forms meet all of the rules for a formal advance directive. Using the special form is the best way to make sure that your wishes are carried out.

When does an advance directive go into effect?

A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care choices. When you make a health care power of attorney, you can name the doctor or mental health provider you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor or mental health provider. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, your Health Care Power of Attorney may make treatment decisions for you. An advance instruction for mental health treatment expires after two years.

What happens if I change my mind?

You can cancel your living will anytime by informing your doctor that you want to cancel it and destroying all the copies of it. You can change your health care power of attorney while you are able to make and make known your decisions, by signing another one and telling your